STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335538	A. Building B. Wing	12/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Concord Nursing and Rehabilitation Center	300 Madison Street Brooklyn, NY 11216

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on observation, record review, and interviews conducted during an abbreviated survey (652565), the facility failed to ensure that a resident, identified as an elopement risk, received adequate supervision to prevent elopement from the facility. This was evident for one (1) of five (5) residents (Resident #2) sampled. Specifically, on 11/29/2024 at 12:24 AM, Resident #2, who had severely impaired cognition, identified at risk for elopement, and was wearing a wander alert device, exited the facility building undetected by staff. Facility staff became aware Resident #2 was not in the building when Police Officers return the resident to the facility at 12:40 AM on 11/29/2024. Facility staff did not respond appropriately to an activated door alarm on Resident #2's unit. The findings include:The facility's 'Security Guards' policy and procedure dated 08/2019 documented the facility utilizes security guards to protect and provide safety to its residents and staff. Security guards are responsible for patrolling the nursing home's entrances and building, reporting all emergencies and unusual findings immediately to their supervisor. Document daily activities in the log book, assist residents as needed and within their scope of practice, escort personnel from nursing home to parking lot as necessary, assist the police when necessary, monitor telephone calls, review elopement binder every day and familiarize themselves with the residents who are wanderers, check wander guards for functionality daily, enforce nursing home policies regarding misconduct, perform diversified duties and other duties as appropriate when requested. The facility's 'Wander Management Devices/Alarms/Doors' policy and procedure dated 09/01/2023 documented the facility shall utilize wander management systems and devices to promote resident safety while maintaining the east restrictive environment to protect the rights and dignity of the resident. Policy further documents that the wander management device alarms shall be audible and when utilized alert staff if resident wearing the device approaches or breeches the door. For exits that do not require a wander management device, the facility may install coded or alarming doors, and/or alarming magnetic door locks in areas of building that are not secured by a wander management device alarm. The alarm shall be audible and alert staff if the door is breeched.The facility's 'Elopement Prevention' policy and procedure dated 03/13/2024 documented that the facility strives to promote resident safety while maintaining the least restrictive environment to protect the rights and dignity of the resident. The facility maintains a process to identify residents at risk for elopement, implement preventative strategies for those identified as an elopement risk, and conduct a missing resident procedure when necessary. Resident #2 was admitted to the facility from the hospital with diagnoses including Non-Traumatic Brain Dysfunction, and Alzheimer's Disease.The Minimum Data Set (a resident assessment tool) dated 09/18/2024 documented Resident #2 had severely impaired cognition.A review of the Comprehensive Care Plan for Potential risk for elopement related to cognitive impairment/decline was initiated on 03/21/2023. The interventions documented for staff to provide a wander alert device, document all behaviors and distract resident from wandering by offering pleasant diversions. An Elopement Evaluation dated 09/18/2024 documented Resident #2 scored high risk for elopement. The interventions included identifying triggers for wandering, enhanced monitoring for exit seeking behavior, and place wander alert device on Resident #2's left wrist. A review of an Enhanced Monitoring sheet dated 11/28/2024 showed Resident #2 was being monitored every thirty minutes and was last seen at 11:00 PM. A nursing note dated 11/29/2024 at 1:06 AM by Registered Nurse Supervisor #2, documented Resident #2 returned to the facility by Police Officers on routine rounds. They found Resident #2 behind the facility. On return at 12:40 AM, Resident #2 stated they did not have any discomfort and that they wanted to go home. Resident #2 was assessed and there were no abnormal findings. Resident #2 was taken to their room where staff continued enhanced visual monitoring. The Police Officers asked to see all exit doors on the third floor, and all were in working order. Wander alert device check was done and was functioning as well. The facility's investigation dated 11/29/2024 documented that on 11/29/2024 at 12:40 AM, Resident #2 was brought back to the facility by the police. Resident #2 was wearing their wander alert device. Resident #2 was unable to disclose how they got out of the building but communicated that they wanted to get fresh air on their face. Resident #2 was assessed by Registered Nurse Supervisor #2 and had no injuries, no complaints of discomfort and no evidence of emotional distress. The facility concluded that an elopement did occur, however, there is no reason to believe that any abuse or neglect occurred. During a telephone interview on 10/02/2025 at 11:59 AM, Certified Nursing Assistant #6 stated they were assigned to Resident #2 on the 3:00 PM - 11:00 PM shift and conducted corridor monitoring from 11:00 PM- 12:35 AM on 11/29/2024. They stated they are unsure about the last time they saw Resident #2, but that the resident